It is, thereupon, on this _____ day of _____, 1991, ORDERED as follows:

AS TO DEFENDANT'S NOTICE OF MOTION DATED MARCH 5, 1991

1. That all prayers contained in said Notice of Motion are denied with the exception of the following:

A. Defendant's application to hold plaintiff in violation of litigant's rights for her failure and refusal to allow visitation is reserved pending the Court interviewing the two minor children.

B. That defendant shall provide letters from the Government of the United States and Israel that are presently no valid passports issued in his name.

C. Pursuant to plaintiff's consent, plaintiff and her family are restrained from entering defendant's residence without defendant's prior permission.

D. Both parties are restrained from contacting the other, the other's family or the other's place of employment, except for emergencies.

E. If plaintiff has possession of the family photo album, she will provide it to defendant for duplication at his expense.

AS TO DEFENDANT'S CROSS NOTICE OF MOTION DATED MARCH 12, 1991

2. That said Notice of Cross Motion is denied in its entirety.

THOMAS P. ZAMPINO, J.S.C.

Consent is hereby given to the form of the within Order.

Roni Giladi, Defendant
Pro Se

ARTHUR E. HELFT, M. D., F.A.C.S.
31 WASHINGTON SQUARE WEST
NEW YORK, N. Y. 10011

TEL. (212) 460-5505

January 30, 1995

The State Insurance Fund
Medical Division
199 Church Street
New York, New York 10007

RE: Claim No: 38847620 -044
Date of Accident: 06/30/93
Seq. No: 001
Claimant: Giladi, Roni
Examined: 1/26/95

Dear Sir:

HISTORY

The patient is a 42 year old video production worker who stated that on June 30, 1993 while loading heavy video equipment into a truck and while trying to prevent the equipment from falling, he developed low back pain radiating to both legs. He was seen at the Employee Health Service of Albert Einstein Hospital where he was employed and was treated with medication. He received care at the Health Service while working intermittently and subsequently received therapy from Dr. Popescu. In August 1993, he stopped working and has not returned to work since that time. He saw Dr. Cohen in neurology consultation and an MRI done on November 5, 1993 was reported as showing a herniated disc at L5-S1. Epidural blocks were given which he states were not helpful and though he tried to return to work in August 1994, he was unable to do so. He is continuing under the care of Dr. Cohen every month but is no longer receiving physiotherapy. At the end of 1990 he developed numbness and pain in his left thumb, index and middle fingers and came under the care of Dr. Strauss in February 1991. An EMG was performed and he was advised that he had carpal tunnel disease of the left wrist and an ulna nerve entrapment. In December 1991, surgery was performed by Dr. Strauss at Montefiore Hospital but the surgery was not helpful. In May, 1993 he developed numbness in the thumb, index and middle fingers of the right hand and was again advised to have surgery by Dr. Strauss. He feels that the condition in his right hand developed because of overuse of the right hand following the surgery performed on his left hand.

COMPLAINTS

At the present time the patient complains of constant low back pain which is worse after bending, coughing, sneezing, or prolonged sitting or standing. The pain which is located more on the right side, radiates to both legs and is relieved by hot baths, lying

down and analgesics. He complains of weakness, loss of grip and loss of sensation in the left ring and pinky fingers. He also has numbness in all the fingers of his right hand particularly after writing or typing.

PHYSICAL EXAMINATION

The patient is a 5'11" approximately 200 pound man who sat with discomfort and was wearing bilateral wrist splints and wearing a lumbosacral support. Examination of the lower back revealed no evidence of spasm. Forward flexion was performed to the level of the knees and he had complaints of pain. He resisted extension of the back though lateral flexion and rotation were within normal limits. Straight leg raising was performed to 10 degrees bilaterally and he had complaints of pain. He lay down on the table and got up in a side-ways manner. The Achilles and patella reflexes were active and equal. Dorsi-flexion of both ankles, extension of both big toes and sensation in both lower extremities was normal. Examination of the left wrist revealed a healed scar over the volar aspect of the left wrist extending down onto the hand. There was also a well healed 6 inch scar over the medial aspect of the distal humerus extending to a point below the elbow. He complained of decrease sensation over the 4th and 5th fingers of the left hand. He also complained of dullness to pin-prick over the entire right hand. Tinel's sign was positive bilaterally. He made a normal fist but had a weak grasp bilaterally. Shoulder and elbow motion was within normal limits.

SUMMARY AND CONCLUSIONS

The patient is a 42 year old video production worker who stated that on June 30, 1993 while trying to prevent equipment from falling he developed low back pain. An MRI supposedly showed a herniated disc at L5-S1. He has continuing complaints of low back pain and physical examination revealed a limitation of forward flexion and straight leg raising. He also gives a history of carpal tunnel disease and ulna nerve entrapment in the left upper extremity which was treated with surgery in December 1991, and at that time was not considered a workers compensation injury by his surgeon. He is not working and has a moderate to marked partial disability related to his back. Further epidural steroid injections should be authorized.

Very truly yours,

ARTHUR E. HELFT, M.D.

cc: Workers' Compensation Board
Dr. J. Cohen

COS204

Karen Gilardi [illegible] The Stahl [illegible]

1/26/95 [illegible] 10 Am

42 video production work x 13 yrs. Does most of his work with his (L) hand.

6/30/93
While loading heavy video equipment into a truck he tried to prevent it from falling + he developed LBP going to both legs.
Went to Employee Health Svce Rx c medication.
Was oow sev days. + cont to receive care at Health
Svce while working intermittently.
Saw Dr. Popesku (rehab) who Rx c p.t.
In Aug 93 he stopped working + [illegible] to work since
Later saw Dr. Cohen in neurology consult. MRI done in 11/5/93 supposedly [reported by Dr. Petrizzo] herniated disc at L5-S1
Had epidural block [illegible] helps very much.
Tried to ret. to work in Aug 94. but had to stay off x several days.
Under care of Dr. Cohen q mo.
No longer receiving p.t.

At end of 1990 had numbness + pain in the (L) 1,2,3 fingers after prolonged working.
Saw Dr. Strauss in 2/91 Had EMG. He was advised that he had carpal tunnel disease (L) wrist. + ulnar nerve entrapment.
Had surg 12/91 at Montefiore Hosp. by Dr. Strauss.
Surg didn't help at all.
In May 93, had numbness in 1,2,3 fingers of Rt hand. Saw Dr. Strauss who advised surg. Dr. Goldstein. who suggested EMG
Diagnosis confirmed by Dr. [illegible] he examined the Rt.
Pt feels that after surg on (L) he

COMP

Constant LBP, worse on bending or coughing or straining or prolonged sitting or standing. Relieved by lying down [illegible]. Pain is more on baths. Takes extra strength Tylenol. Pain is more on rt. side radiates to both legs mostly to Rt side.

not improving.

c/o weakness & loss of grip in (L) hand. c/o loss of sensation on (L) ring + pinky finger. Has pain in (L) elbow. Still has some numbness but not as much as preop.

c/o numbness in all fingers of Rt hand. Worse on writing 20 minutes or typing. No definite weakness in Rt hand.

PE 5'11 ~ 200
Sitting but in discomfort.
wearing bilat wrist splints.
Wearing L-S support.
F.F. to knees c/o pain
SLR [illegible] 10° bilat.
PT + Patellar + =
D.F + ext WNL.
Sen WNL.

Rest into ext. Lat flex + rot ok.
Lies down + gets up sideways.

c/o dullness to pinprick entire Rt hand
& over 4th & 5th fingers (L) hand
Healed scar (L) volar wrist on [illegible] hand.
6" scar (L) distal medial humerus extending below the elbow
Tinel positive bilat. [illegible] but weak grip WNL.
Shoulder & elbow [illegible]
bilat

COS206

Mod = Marked   auth ep. steroid   Doubt causal relationship for wrist. Orig surgeon did

NORMAN PETIGROW M.D., F.A.C.S.
119 West 57th Street, Suite 612
New York, NY 10019

August 3, 1994

Exam Type	:	COMPENSATION
Carrier	:	The State Insurance Fund
Claimant	:	Roni Giladi
Carrier File #	:	3839 8020-044
MEDFACTS File #	:	35335
MEDFACTS Exam #	:	14226
WCB File #	:	935 6779
Date of Accident	:	06/30/1993
Employer	:	Yeshiva University
Sequence #	:	004

Dear Sir:

As per your request, I interviewed and conducted an orthopedic examination on the above captioned patient in our office today.

HISTORY:

The claimant is a 42-year old video production worker employed at Yeshiva University for 13 years. He alleges that on 6/30/93 while lifting and carrying heavy equipment he developed sudden pain in his lower back and numbness and tingling in his right toe. He also complained of a exacerbation of pain and numbness in both hands. Patient previously had a left carpal tunnel release performed in December of 1991 by a Dr. Strauss in Montefiore Hospital. He had also noted the development of some numbness in the fingers of his right hand starting in May of 1993. He was initially treated by the employee Health doctor who told him to rest at home. He intermittently rested at home, returned to work and rested again and finally in August of 1993 he no longer was able to work. He was seen by Dr. C. Popescu of 1825 Eastchester Road, a physiatrist and started on a physical therapy program. He also was seen by Dr. Joel Cohen of 1575 Blondell Avenue in the Bronx, a neurologist who thought that he had a herniated disc. His hand symptoms were treated by Dr. Benisse Lester, an orthopedic surgeon at Montefiore who felt that he had an exacerbation of right carpal tunnel syndrome and recurrent left carpal syndrome. An MRI of the lumbo sacral spine on 11/5/93 revealed a herniated disc at L5-S1. Patient remains out of work complaining of pain in his lower back and pain and numbness in both hands. He sees his physicians occasionally and takes medication for pain.

PAST MEDICAL HISTORY:

Otherwise unremarkable.

PHYSICAL EXAMINATION:

Reveals a well-nourished, well-developed male, 5'11" tall, weighing 200 lbs. He has brown/gray hair, brown eyes and is right handed.

EXAMINATION OF THE LUMBO SACRAL SPINE:

There is no tenderness or spasm of the para spinal musculature. Straight leg raising test is positive at 40 degrees on the right. Deep tendon reflexes are 0-1+. There is 10-15% decrease in range of motion on flexion and extension. Patient cannot walk on his heels and toes and walks without a limp.

REVIEW OF MEDICAL RECORDS:

The available records are reviewed.

DIAGNOSIS:

1. Status post lumbo sacral strain with herniated disc L5-S1.

COMMENTS:

Assuming the history to be correct, the aforementioned injury is felt to be causally related. At the present time the patient has a mild partial disability of the lumbo sacral spine and requires continued physical therapy in a back hardening program 3 times a week for an 8-12 week period and should be re-examined. He is unable to return to work.

I am available to testify Tuesday mornings.

I certify and affirm that the foregoing report is true to the best of my knowledge under penalty of perjury.

Respectfully submitted,

Norman Petigrow, M.D.

Norman Petigrow, M.D., F.A.C.S.
NP/ke

8/3/94

cc: Workers Compensation Board
Dr. Joel Cohen

MEMBER
AMERICAN ACADEMY OF
DISABILITY EVALUATING PHYSICIANS

ALBERT EINSTEIN COLLEGE OF MEDICINE

OF YESHIVA UNIVERSITY

1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

September 6, 1983

RE: Oni Galadi

Mr. Galadi is a 26 year old male who was involved in an automobile accident a year and one-half ago when he was hit from behind. At that point he was thrown against the windshield and developed heaviness and tingling in both arms. He was seen and followed at St. Barnabas Hospital in New Jersey where he was given a collar. He subsequently continued to have problems including weakness of his arms and pain in the neck and some difficulty climbing stairs. He had a workup at St. Barnabas which included EMG studies the results of which are not presently available as well as a myelogram which was seen by Doctor Thal and reviewed with Doctor Lantos and was apparently normal.

Electrophysiological Testing.

Nerve conduction and late responses. Nerve conduction of mixed nerve median and bilaterally from palm to wrist showed an amplitude of 50 microvolts, conduction velocity of 60 meters/second. From palm to digit two showed a conduction velocity of 61 meters/second and an amplitude of 35 microvolts. Digit three to wrist potential showed an amplitude of 9 microvolts bilaterally orthrodromically, conduction velocity of 62 meters/second. Median distal latency was 3.4 milliseconds bilaterally. Distal latency for the ulnar was 2.8, amplitude was 7K, conduction velocity 62 meters/second above the ulnar groove and 58 across the ulnar groove.

EMG was done in the following muscles: bilaterally the biceps, triceps, brachial radialis, extensor carpi radialis longus, flexor carpi radialis, first dorsal interosseous and APB. All muscles were quiet at rest and showed motor units of normal amplitude and duration with complete recruitment with full effort.

Impression.

There is no electrophysiological evidence of neural

entrapment, cervical radiculopathy or brachial plexus injury to explain the patient's symptoms.

Jerry Kaplan, M.D

Jerry G. Kaplan, M.D.

JGK/ELOMTS/mmp

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY
1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

RONNIE GILIADI September 11, 1987

Mr. Giliadi is a 36 year old right handed man who works in the Audio-Visual Department at Einstein. Last Saturday night, which would have been September 5, Mr. Giliadi supported a superficial laceration of his left wrist proximal to the carpal tunnel. Apparently an artery was not injured but because of venous injury, several sutures were placed in the emergency room at St. Barnabas Hospital in Livingston. Mr. Giliadi was aware of numbness in the palmar aspect of his left hand immediately after the injury. As well, any trauma such as drying of the hand would be associated with a shock-like sensation in the hand. He really could not evaluate strength in the hand.

On physical examination, there was some reddness and swelling with tenderness around the suture site. He had some dysesthesia in the median nerve distribution but not in the digits. There was probably some weakness, about 4+/5 range in the left APB. There was some equivocal weakness in the ulnar and radial muscles including dorsal interossei, digiti quinti minimi, and lumbericals of the 4th and 5th digits. Equivocal decrease in pin that may be in the ulnar distribution on the left. I had Dr. Kaplan look at Mr. Giliadi and he is being seen by a surgeon today to have appropriate management of his wrist cared for.

HAC:mt

Howard A. Crystal, M.D.

Dr. Dhalech wanted explore, possible anastamosis. Pt ambivalent, not returned most phone call. Saw another MD with opinion — concurred possible repair.

HAC

006211

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY
1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

PATIENT: RONI GILADI
DATE: 11/87

Mr. Giladi continues to have complaints of pain in the proximal left humerus as well as decreased dexterity in the left hand. He reports tingling and numbness of the first three fingers, especially when he attempts to use the hand.

Examination reveals normal median function but he has quite a bit of tenderness to any movements of the hand. He has swelling around the scar.

Clinical neurophysiological testing was performed in the left median. The distal motor latency is 4.52 msec; the amplitude is 9 mv; conduction in the elbow to wrist segment is 51.2 mps; axilla to elbow is 60.8 mps; F wave 29 msec. Conduction from digit 2 to wrist on the left 3.2 mcv, amplitude 39 mps. Palm to wrist is 31 mps. Palm to digit is 50 mps. Left ulna potential - motor latency 2.36, amplitude 6 mv, conduction velocity 50 mps from elbow to wrist, 31 mps across the elbow, 68 mps from axilla to elbow. F wave is 27 msec. Sensory digit 5 to wrist 4.2 mcv, 52 mps. Mixed nerve from wrist to elbow is 65 mps, across the elbow is 36 mps. Right median distal latency 5.28, amplitude 12 mv, conduction velocity 50 mps, F wave 30 msec. Axilla to elbow conduction, 63 mps. Digit 2 to wrist 2.8 mcv, amplitude 35 mps. Palm to wrist conduction is 28 mps. Ulna on the right, latency 3.2, amplitude 5.2 mv, 56 mps from elbow to wrist, 40 mps across the elbow. Conduction from axilla to elbow is 56 mps, F wave 31 msec. Right digit 5 to wrist, amplitude 2.8 mcv, conducting at 42 mps. Sural nerve action potential recorded orthodromically 16 mcv, conducting at 43 mps. H reflex is 27 msec.

EMG of the left APB shows 2+ denervation with normal motor units. First dorsal interosseous is quiet with normal motor units. Flexor digitorum sublimis is normal. Flexor carpi radialis on the left is normal. Flexor pollicis longus is normal. Left pronator teres is normal. Left triceps is normal. Left extensor indicis proprius is normal. Left extensor digitorum communis normal. Right APB is 2+. Right first dorsal interosseous is normal. Right C7 paraspinous is 1+.

IMPRESSION: There are multifocal entrapments involving the

median nerve at both wrists and the ulnar nerves at both elbows, as well as questionable C7 radiculopathy, based on the findings of denervation of the cervical paraspinous muscles. There is no electrophysiological evidence of underlying generalized peripheral neuropathy.

The patient's most symptomatic site is the median nerve on the left. Whether he has swelling post-operatively which may be giving him a carpal tunnel syndrome is unclear at the present time. I have opted to place him on Prednisone for a week and to follow him closely. Should he continue to have symptoms, I will ask Dr. Goldstein to see him again for further evaluation. I have discussed this with the patient and will see him in 1 to 2 weeks' time.

Jerry G. Kaplan, M.D.

JGK:lw
Med-Scribe

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

ULNAR NERVE CONDUCTION STUDY

NAME: Liliendi

DATE: 11/13/87

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
( )WRIST		6000	2.86			
BELOW ELBOW			7.54	289	50.2	
ABOVE ELBOW				490	31.2	
AXILLA				180	68.1	
ERB'S POINT						
F WAVE						

SENSORY

( )WRIST	Digit 5					
BELOW ELBOW - Wrist			3.22	210	65.2	
ABOVE ELBOW - Wrist	above elbow		5.3	75	36	
AXILLA						
ERB'S POINT						
D5	Wrist	4.2	2.63	134	52.3	

MIXED

WRIST	Bel.Elbow Above Elbow					

006214

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Grundi DATE: 11/6

TEMP: _____ HEIGHT: 5'11

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(L) WRIST		9,000	4.52			
ELBOW			8.88	220	51.2	
F WAVE	29.1					
Axilla			12.6	230	60.8	

SENSORY

(2) D2→W		3.2	3.79	150	39.5	
P→W		2.13	8	6.5	30,5	
P→D2				8.5		
						006215

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

LOWER EXTREMITY NERVE CONDUCTION STUDY

NAME: GRADI, RONI

DATE:

TEMP: HEIGHT:

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(L) SURAL NERVE						
ORTHODROMIC						
ANTIDROMIC		16.4	2.6	105	43	
( ) PERONEAL NERVE						
ANKLE	Extensor Digitorum Brevis					
BELOW FIBULAR HEAD						
ABOVE FIBULAR HEAD						
F WAVE						
( ) TIBIAL NERVE (MEDIAL PLANTAR NERVE)						
ABOVE MEDIAL MALLEOLUS						
BELOW MEDIAL MALLEOLUS						
H REFLEX			27.3			
F WAVE						

006216

DEPARTMENT OF NEUROLOGY — DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Gilardi DATE: 11/13

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(R) WRIST		12,000	5.28			
ELBOW			9.96	235	50.2	
F WAVE	29.8					
Axilla			13.1	205	63.6	

SENSORY

R D2→W		2.8	4.04	145	35.8	
R P→W		3.6	2.5	70	28	

006217

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

ULNAR NERVE CONDUCTION STUDY

NAME: Giladi

DATE: 11/13/87

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(R) WRIST		5,200	3.28	225		
BELOW ELBOW			7.13	100	55.9	
ABOVE ELBOW			9.68	180	40.3	
AXILLA			13			
ERB'S POINT						
F WAVE	31					

SENSORY

( ) WRIST	Digit 5					
BELOW ELBOW						
ABOVE ELBOW						
AXILLA						
ERB'S POINT						
D5	Wrist	2.8	3.03	125	41.2	

MIXED

WRIST	Bel.Elbow Above Elbow					

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DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

ULNAR NERVE CONDUCTION STUDY

NAME: Gilaide

DATE: 12/23/87

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORD-ING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(R) WRIST		6.6	3.0			
BELOW ELBOW			7.1	235	57	
ABOVE ELBOW			9.2	100	40	
AXILLA			12.5			
ERB'S POINT			15.1			
F WAVE	31					

SENSORY

( ) WRIST	Digit 5					
BELOW ELBOW						
ABOVE ELBOW						
AXILLA						
ERB'S POINT						
D5	Wrist					

MIXED

WRIST	Bel.Elbow Above Elbow					

006219

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Hilaedi, Roni

DATE: 12/23/87

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(R) WRIST		6.8	4.24			
ELBOW			9.16	24.5	49.7	
F WAVE						

SENSORY

						006220

DEPARTMENT OF NEUROLOGY
DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Cilardi, Rose DATE: 12/23/97

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(1)WRIST		9.4	5.32			
ELBOW			9.96	235	52.9	
F WAVE	30		17.9	17.5	60.7	
ERBS			15.9			
hi axilla			18.6	50	65.7	

SENSORY

LD2→w		3.4	4.14	145	35	
motor						
above Scar. Upper wrist	APB		6.04	50		
w Rust Crease	APB		5.3			→53- errors in measurement

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

ULNAR NERVE CONDUCTION STUDY

NAME: Heladi

DATE: 12/23/87

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(L)WRIST		5.9	3.66			
BELOW ELBOW			8.44	230	48.1	
ABOVE ELBOW			11.2	105	30.5	
AXILLA			13.9	170	65.3	
ERB'S POINT			16.9			
F WAVE	32.5					

SENSORY

( )WRIST	Digit 5					
BELOW ELBOW						
ABOVE ELBOW						
AXILLA						
ERB'S POINT						
D5	Wrist	4	2.52	120	47.2	

MIXED

WRIST	Bel.Elbow Above Elbow					

C06222

DATE 12/23/07

MUSCLE	SPONTANEOUS ACTIVITY	MOTOR UNITS DURATION	RECRUITMENT	COMMENTS
(L) 1ST DI	0	N	Cine	
FCR	0	N		
FCU	0	N		
FPL	0	N		

ALBERT EINSTEIN COLLEGE OF MEDICINE

OF YESHIVA UNIVERSITY

1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

PATIENT: GILADI, RONI
DATE: 7/25/88

HISTORY: Mr. Giladi continues to have pain in his arm, and now has pain in the left shoulder. He reports that he feels weak in his arm, as well as on the left side. Dr. Spinner apparently felt that he had a form of reflex sympathetic dystrophy, and has given him exercises.

PHYSICAL EXAMINATION: On examination, he continues to have tenderness over the scar in the lower volar aspect of the left forearm. He has decreased range of motion of his left shoulder and tenderness there. He tends to hold his left hand in a clawed position, but there are no skin changes and no coldness. In fact, he has calluses on his left hand.

IMPRESSION: It is my feeling that the patient may be developing a shoulder-hand syndrome. I will discuss this with Dr. Spinner. Perhaps physical therapy should be increased.

Jerry G. Kaplan, M.D.
Associate Professor of Neurology
Director, EMG Laboratory
Albert Einstein College of
Medicine/Montefiore Medical
Center

JGK:lw:er

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY
1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

July 26, 1988

RE: RONI GILADI

To Whom It May Concern:

Roni Giladi had an injury to the superficial median sensory nerve at the left wrist, which was operated on on September 21, 1987. Since then he has been incapacitated by a local pain, tingling, and numbness, in the hand as well as by upper arm and shoulder pain. It seems to me now that he is developing a shoulder-hand syndrome, with pain and limitation of movement in the hand, as well as decreased passive range of motion and pain in the left shoulder. In addition, he has multi-focal entrapments of the median ulnar nerves, bilaterally in the arms occurring at the wrist and elbows respectively. Mr. Giladi is in no way a candidate for military duty, and would probably represent a hazard in any military situation. I hope this letter will serve to excuse him from further military duty.

Should there be any difficulties or any questions, please do not hesitate to contact me.

Sincerely yours,

Jerry G. Kaplan, M.D.
Associate Professor of Neurology
Director, Electromyography
Laboratories
Albert Einstein College of Medicine
Montefiore Medical Center

JGK:ln

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY
1300 MORRIS PARK AVENUE, BRONX, N.Y. 10461

THE SAUL R. KOREY
DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

December 29, 1988

To Whom It May Concern:

Roni Giladi is my patient. He has painful peripheral nerve entrapments. He took Xanax 0.25 mg for pain control under the direction of Dr. Morton Spinner. This was not used as an anxiolytic or for psychotropic effects.

Jerry G. Kaplan, M.D.

Associate Professor of Neurology
Director, EMG Laboratory
Albert Einstein College of Medicine
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DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

April 19, 1989

Mr. Roni Giladi
P.O. Box 127
Millburn, New Jersey 07041

Dear Roni:

I recently learned that you have stopped seeing Dr. Spinner. As we have discussed, I think that you must continue to receive ongoing therapy and observation for your hand problems. I think this is in your best interest, especially considering that your career depends on the use of your hands. In addition, I would greatly stress that you should begin to see Dr. Ronald Kanner because of the pains you have been having in your left hand. I have spoken to Dr. Kanner about you on numerous occasions and he has agreed to see you.

If you have any difficulties with any of this, please contact me at your earliest convenience.

Very truly yours,

Jerry G. Kaplan, M.D.
Associate Professor of Neurology
Director, EMG Laboratory
Albert Einstein College of Medicine
Montefiore Medical Center

JGK:lw/dvf

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DEPARTMENT OF NEUROLOGY

PHONE: (212) 430-2833

Brain dated on 1/23/90 DC

PATIENT: RONI GALADI

Date 1-9-90

Mr. Galadi continues to have pain in his arm. He has pain from the left wrist to the elbow to the shoulder. This is worse with movement. It is worse while holding a telephone. He has nocturnal predominance. He occasionally has numbness of the fingers, especially the fourth finger. He says this is interfering with his job. He has seen Dr. Ron Kanner and other people at the pain service, who feel that a lot of his difficulties relate to anxiety and depression and stress around his divorce.

EXAMINATION: He has normal strength, he has some shading of sensation in the lowers.

He has tenderness over the wrist and over the upper medial forearm. Extensive nerve conduction studies were done, the results of which are on the accompanying sheets. He appears to have rather significant slowing of median nerve conduction across the left wrist and ulnar conduction across the left elbow. The right upper extremity was not sampled as this is not particularly symptomatic. Nerve conductions in the lower once again failed to show any electrophysiological evidence of underlying generalized peripheral neuropathy.

IMPRESSION: The patient continues to have entrapments which may or may not be related to his underlying condition. They are somewhat severe and he does have some symptoms that might be referable to carpal tunnel syndrome. I therefore have told him to try a wrist splint on the left and put him on very low dose prednisone (5 mg a day) for about one week. I will see the patient in several weeks for followup.

JGK

Jerry G. Kaplan, M.D.
Associate Professor of Neurology
Director, EMG Laboratory
Albert Einstein College of Medicine
Montefiore Medical Center

JGK:lw/mct

advanced mr imaging
an affiliate of the Albert Einstein College of Medicine

PATIENT NAME	DOB	AGE	SEX	DATE
Ronnie Giladi	3/5/50		M	8/25/89

MRI EXAMINATION	FILE NUMBER	PATIENT LOCATION
Left Wrist		

REFERRING PHYSICIAN	COPY TO
Dr. Kaplan	

History: nerve damage

Technique: Coronal T-1 weighted sequencing, axial T-1 and T-2 double echo sequencing, providing overall fair spatial resolution and contrast. Images are degraded by patient motion perhaps secondary to shoulder discomfort.

Findings: There is apparent hyperintense T-2 signal in what appears to be the median nerve in the region of the carpal tunnel best appreciated on the axial double echo sequence at S18.5 and S22.5. The more distal section being at the level of the hook of the hamate. The nerve and/or surroundings may be slightly increased in size. There is only a vague suggestion of scarring in the superficial palmar subcutaneous tissue to correspond to patient's prior stab wound and surgery. No other definite abnormalities identified.

IMPRESSION:

Apparent increased T-2 signal in the region of the median nerve at the level of the carpal tunnel suggesting the possibility of non-specific edematous/inflammatory changes involving the nerve in this region potentially related to carpal tunnel syndrome, prior stab wound and/or post surgical changes. The images are unfortunately degraded by patient motion.

Kenneth L. Weiss, M.D.

006229

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Giladi, Roni

DATE: 1-9-90

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORD-ING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
( )WRIST						
ELBOW						
F WAVE						

SENSORY

RADIAL						
D_1	W	5.2mV	1.98	115	58	

006230

ALBERT EINSTEIN COLLEGE OF MEDICINE

DEPARTMENT OF NEUROLOGY

DIVISION OF ELECTROPHYSIOLOGY

LOWER EXTREMITY NERVE CONDUCTION STUDY

NAME: GILADI, RONI DATE: 1-9-90

TEMP: _____ HEIGHT: _____

STIMULUS	RECORDING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(R) SURAL NERVE						
ORTHODROMIC		8uV	2.4	120	50	
ANTIDROMIC		---				
(R) PERONEAL NERVE						
ANKLE	Extensor Digitorum Brevis	3.6	4.56			
BELOW FIBULAR HEAD			11.9	400	54	
ABOVE FIBULAR HEAD			12.8	50	543	
F WAVE			54.8			
( ) TIBIAL NERVE (MEDIAL PLANTAR NERVE)						
ABOVE MEDIAL MALLEOLUS						
BELOW MEDIAL MALLEOLUS						
REFLEX			29.7			
WAVE						

DEPARTMENT OF NEUROLOGY — DIVISION OF ELECTROPHYSIOLOGY

MEDIAN NERVE CONDUCTION STUDY

NAME: Giladi, Roni DATE: 1-9-90

TEMP: _____ HEIGHT: _____

MOTOR

STIMULUS	RECORD-ING	AMPLITUDE	LATENCY (MS)	DISTANCE (MM)	NERVE CONDUCTION VELOCITY (M/SEC)	COMMENTS
(L) WRIST	APB	7.2	3.68			
ELBOW			8.14	255	57.1	
F WAVE			28.2-32.5			
Above Elbow		7.7	9.38	82	66.1	
AXILLA Erb's Pt		6.9	11.1 14.2	118	66.2	

SENSORY

D_3	W	absent				
P	W	absent				
D_2	W	3.4	3.82	146	38.2	
P	W		2.39	75	31.3	
P	D_2		1.65	85	51.5	

CLINICAL NEUROPHYSIOLOGY LABORATORY
MOTOR AND SENSORY NERVE CONDUCTION EXAMINATION

Date 3/8/91

Patient Name Roni G[illegible]

Age 39 Sex ♂ Height([illegible]

Extremity Temp(C) 35° Handedness [illegible]

006233

NERVE / ED	RECORD SITE	STIMULATE SITE	LATENCY (msec)	AMP (uv)	DURATION (msec)	DISTANCE (mm)	VELOCITY (m/sec)	REMARKS/ COMMENTS
[illegible] (S)	WRIST	D2	3.3	3.8	1.1	150	45.1	Ab, LA
EDIAN (Mx)	WRIST dist	PALM	1.5	21.0	1.4	70	46	Ab, Slow
EDIAN (S)	D2	PALM	1.1	14.8	1.8	75	65.7	N
ULNAR (S)	WRIST	D5	2.2	8.4	1.6	135	60.2	N
[illegible] (Mx)	SEL	WRIST						
	AEL	WRIST						
EDIAN (M)	APB	WRIST	3.8	11800	6.6	65		N
EDIAN (M)	APB	ELBOW	8.3	9700	6.7	230	51.1	N
EDIAN (M)	APB	WRIST	32-29					N
ULNAR (M)	ADM	WRIST	2.5	66	6.1	65		N
ULNAR (M)	ADM	BEL	6.8	62	6.5	230	53.4	N
ULNAR (M)	ADM	AEL	9.6	6[illegible]	6.9	105	37.5	Ab, Slow
ULNAR (F)	ADM	WRIST	32-30					N
RADIAL (S)	WRIST	[illegible]	[illegible]	[illegible]	[illegible]	9.5	53.3	N
[illegible] (S)	[illegible]	W	[illegible]	[illegible]	[illegible]	105	58.9	N
[illegible]	APB	[illegible]	[illegible]	[illegible]	6.4	55	69.4	N
[illegible]	[illegible]	35	[illegible]	[illegible]	6.8	[illegible]	[illegible]	N
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	59.5	N

MOTOR AND SENSORY NERVE CONDUCTION EXAMINATION

Date 3/8/91

Patient Name Roni Giladi

Age 39 Sex ♀ Height(inches) 76"

Extremity Temp(C) 36° Handedness ambidex

006234

SIDE R/L	NERVE TESTED	RECORD SITE	STIMULATE SITE	LATENCY (msec)	AMP (uv)	DURATION (msec)	DISTANCE (mm)	VELOCITY (m/sec)	REMARKS/ COMMENTS
(R)	MEDIAN (S)	WRIST	D2	3.5	4.4	1.3	155	42.8	Ab, LA, Slow
	MEDIAN (Mx)	WRIST	PALM	1.7	24.0	1.0	70	41.1	Ab, Slow
	MEDIAN (S)	D2	PALM	1.5	5.8	1.2	80	51.9	N
	ULNAR (S)	WRIST	D5	2.4	4.4	1.1	125	52.5	Ab, LA
	ULNAR (Mx)	BEL	WRIST						
	ULNAR (Mx)	AEL	WRIST						
	MEDIAN (M)	APB	WRIST	3.8	9300	5.6	55		N
	MEDIAN (M)	APB	ELBOW						N
	MEDIAN (F)	APB	WRIST	32-29					N
	ULNAR (M)	ADM	WRIST	2.9	8900	6.2	75		N
	ULNAR (M)	ADM	BEL	6.1	8500	6.4	220	68.7	N
	ULNAR (M)	ADM	AEL	8.7	8100	7.2	110	42.3	Ab, Slow
	ULNAR (F)	ADM	WRIST	34-30					Ab, IR
	RADIAL (S)	WRIST	D1	2.72	42	1.0	130	61.3	N
	LAT CUT (S)	FOREARM	ELBOW	1.7	11.6	1.2	120	70.5	N
	ULNAR (M)	PDI	WRIST	3.5	9600	4.4	140		N
	" "	"	BEL	7.0	6600	7.9	220	62.8	N
	" "	"	AEL	10.2	4700	8.0	110	33.8	Ab, Slow
	" "	"	WRIST	29-28					

CLINICAL NEUROPHYSIOLOGY LABORATORY

MOTOR AND SENSORY NERVE CONDUCTION EXAMINATION

Date 3/9/91

Patient Name RONI GILADI

Age ____ Sex ____ Height(inches) ____

Extremity Temp(C) ____ Handedness ____

SIDE R/L	NERVE TESTED	RECORD SITE	STIMULATE SITE	LATENCY (msec)	AMP (uv)	DURATION (msec)	DISTANCE (mm)	VELOCITY (m/sec)	REMARKS/ COMMENTS
(L)	RADIAL (M)	EIP	ANTEBRAX	3.7	2300	11.0	215		Ab, LA (technical)
		"	MIDARM	5.2	2200	11.6	130	83.8	N
		"	AX	6.3	2400	11.4	95	77.2	N
		"	ERBS	10.0	6100	9.0			N
(R)	RADIAL(M)	EIP	ANTEB. FOS	3.3	2200	10	195		Ab, LA (technical)
(L)	ULNAR (M)	FDI	WRIST	3.7	8700	5.3	120		N
	" "	"	BEL	8.4	6800	6.9	230	50.5	N
	" "	"	AEL	9.5	5300	6.7	105	95.45	

EMG SHEET

3/8/91
DATE

(E- Coni Giladi

LE	FIBS	FASC	MISC	AMP	DUR	POLYPHASIA	PATTERN	COMME
)								
)i	0	0		N	N		Lmx	N
)M	0	0		N	N		Mx	N
DC.	0	0		N	N		Mx	N
R	0	0		N	N		Mx	N
I	0	0		N	N		Lmx	N
2i	0	0		N	N		Mx	N
LT	0	0		N	N		Mx	N
	1+	0						Ab
5	0	0						N
7	0	0						
3	0	0						
TER	1+	0		N	N		Mx	Ab
?	1+	0		N	N		Mx	Ab
)								
	0	0						A
Di	0	0		N	N		Lmx	N

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